

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06107

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dameron		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Dameron		d. STREET ADDRESS Rural	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rural				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Engelbert	Last Beal	4. DATE OF DEATH	Month May	Day 1	Year 1958

5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> March 19, 1882	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming			10b. KIND OF BUSINESS OR INDUSTRY Farm Owner	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA			

13. FATHER'S NAME Alexander Beal	14. MOTHER'S MAIDEN NAME Lucy Ann Dunbar		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. _____	17. INFORMANT Paul Bunbar - Dameron, Md.	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 976 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gun shot of left chest - self inflicted				
20c. TIME OF INJURY Hour _____ P. m. May 1, 1958	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	20f. (City or town) Dameron	(County) St. Marys	(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL SIGNATURE *Wm. D. Boyd* DATE SIGNED
 EXAMINER'S NAME (Type) Wm. D. Boyd, MD 5/1/58

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/5/58	22c. NAME OF CEMETERY OR CREMATORIUM St. Michaels	22d. LOCATION (City, town, or county) Ridge	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 7 '58	24b. REGISTRAR'S SIGNATURE <i>Deb. Smith</i>

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15. Standardization of the English Language

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6121 CERTIFICATE OF DEATH

06108

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Stephen H. Bean		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1872	9. AGE (In years lost birthday) yrs. 85	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Great Mills, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John S. Bean		14. MOTHER'S MAIDEN NAME Mary Elizabeth Fenhagan		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT John S. Bean					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thromb 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Carcinoma of prostate						INTERVAL BETWEEN ONSET AND DEATH 4 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Great Mills		(County)	(State)
21. I certify that I attended the deceased from October , 19 55 , to May 13 , 19 58 , that I last saw the deceased alive on May 92 , 19 58 , and that death occurred after 1 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland									
ACTUAL SIGNATURE P. J. Bean M. D.		DATE SIGNED May 23/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/58		22c. NAME OF CEMETERY OR CREMATORIUM Holy Face		22d. LOCATION (City, town, or county) Great Mills, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 27 '58		24b. REGISTRAR'S SIGNATURE Albert Beach			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be used with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

34

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6122 CERTIFICATE OF DEATH

Reg. Dist. No. 06109

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hollywood			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First William	Middle Wallace	Last Bowles	4. DATE OF DEATH Month May	Day 27,	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 20, 1873	9. AGE (In years lost birthday) 84	IF UNDER 1 YEAR Months 10	IF UNDER 24 HRS. Days 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant & Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Francis Bowles		14. MOTHER'S MAIDEN NAME Ann Saphire Tippett		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or date of service) 217-36-7284		17. INFORMANT Jane C. Bowles		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.0 DUE TO Heart block.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Great Mills, Maryland		(County) (State)	
21. I certify that I attended the deceased from James , 1953 to May 28 , 1958, that I last saw the deceased alive on May 26, 1958 , and that death occurred at 6:30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Great Mills, Maryland							
DATE SIGNED May 28/58							
ACTUAL SIGNATURE <i>P.J. Bean</i>		M.D.					
PHYSICIAN'S NAME (Type) P. J. Bean M.D.		Great Mills, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/30/58		22c. NAME OF CEMETERY OR CREMATORIUM ST. Johns		22d. LOCATION (City, town, or county) (State) Hollywood, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 2 '58		24b. REGISTRAR'S SIGNATURE <i>Alv. eden</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF SOUTH DAKOTA

DEPARTMENT OF

EDUCATION

STATE BOARD OF

EDUCATION

STATE EDUCATIONAL

COMMISSION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6123 CERTIFICATE OF DEATH

Reg. Dist. No. 06110

1. PLACE OF DEATH a. COUNTY St. Marys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mechanicsville		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Effie	First Agnes	Middle Buckler	4. DATE OF DEATH Month Day Year 5 / 15 / 19 58
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3 / 27 / 1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY domestic	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Lyon		14. MOTHER'S MAIDEN NAME Joanna Herbert	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Thomas F. Buckler - Mechanicsville, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the under-lying cause (c). hypertension		INTERVAL BETWEEN ONSET AND DEATH 1 wk	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1958 to May 1958 , that I last saw the deceased alive on 1958 , and that death occurred at 64 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leon Berube M.D.			
ACTUAL SIGNATURE		DATE SIGNED 5/16/58	
PHYSICIAN'S NAME (Type) Leon Berube, MD		Mechanicsville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/17/58	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson- Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE MAY 28 '58	
		24b. REGISTRAR'S SIGNATURE Q. L. Lewis	

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6124 CERTIFICATE OF DEATH

Reg. Dist. No. 281

06112

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		c. LENGTH OF STAY IN 1b 50 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hollywood		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Gerald	Middle Fenwick	Last	4. DATE OF DEATH	Month May	Day 21	Year 1958
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5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3 ? 1877	9. AGE (In years (last birthday) yrs.) 80	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.	16. SOCIAL SECURITY NO.	17. INFORMANT Louis Fenwick Hollywood Md.	Address
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18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}		INTERVAL BETWEEN ONSET AND DEATH 2 years
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of intestine (c) With metastasis to liver		DUE TO
		DUE TO
		(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from Oct 11, 1957 , to May 21, 1958 , that I last saw the deceased alive on May 19, 1958 , and that death occurred at 5 A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Great Mills, Maryland	DATE SIGNED 5/29/58
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ACTUAL SIGNATURE P.J.Bean M.D.	PHYSICIAN'S NAME (Type) P.J.Bean M.D.	Great Mills, Maryland
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/24/58	22c. NAME OF CEMETERY OR CREMATORIUM St. John's	22d. LOCATION (City, town, or county) (State) Hollywood, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE W.Clark Mattingley Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 27 '58	24b. REGISTRAR'S SIGNATURE DeLoach
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6125 CERTIFICATE OF DEATH

06113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall		c. LENGTH OF STAY IN lb 30 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Mary	Middle Richard	Last Fenwick	4. DATE OF DEATH	Month May	Day 15,	Year 19 58
5. SEX	d. COLOR OR RACE Female Colored	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH 1888	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME James Toney			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT Daisey Sommerville Park Hall, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), slating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 3 hours 5 years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Great Mills, Md.	(County) St. Mary's City, Md.	(State) Md.
21. I certify that I attended the deceased from April , 1958, to May 15, 1958 , that I last saw the deceased alive on May 14, 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>P.J. Bean M.D.</i>							ADDRESS (Street, city or town, state) Great Mills, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/19/58		22c. NAME OF CEMETERY OR CREMATORIUM St. James		22d. LOCATION (City, town, or county) (State) St. Mary's City, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR MAY 20 '58		24b. REGISTRAR'S SIGNATURE <i>C. L. Smith</i>		



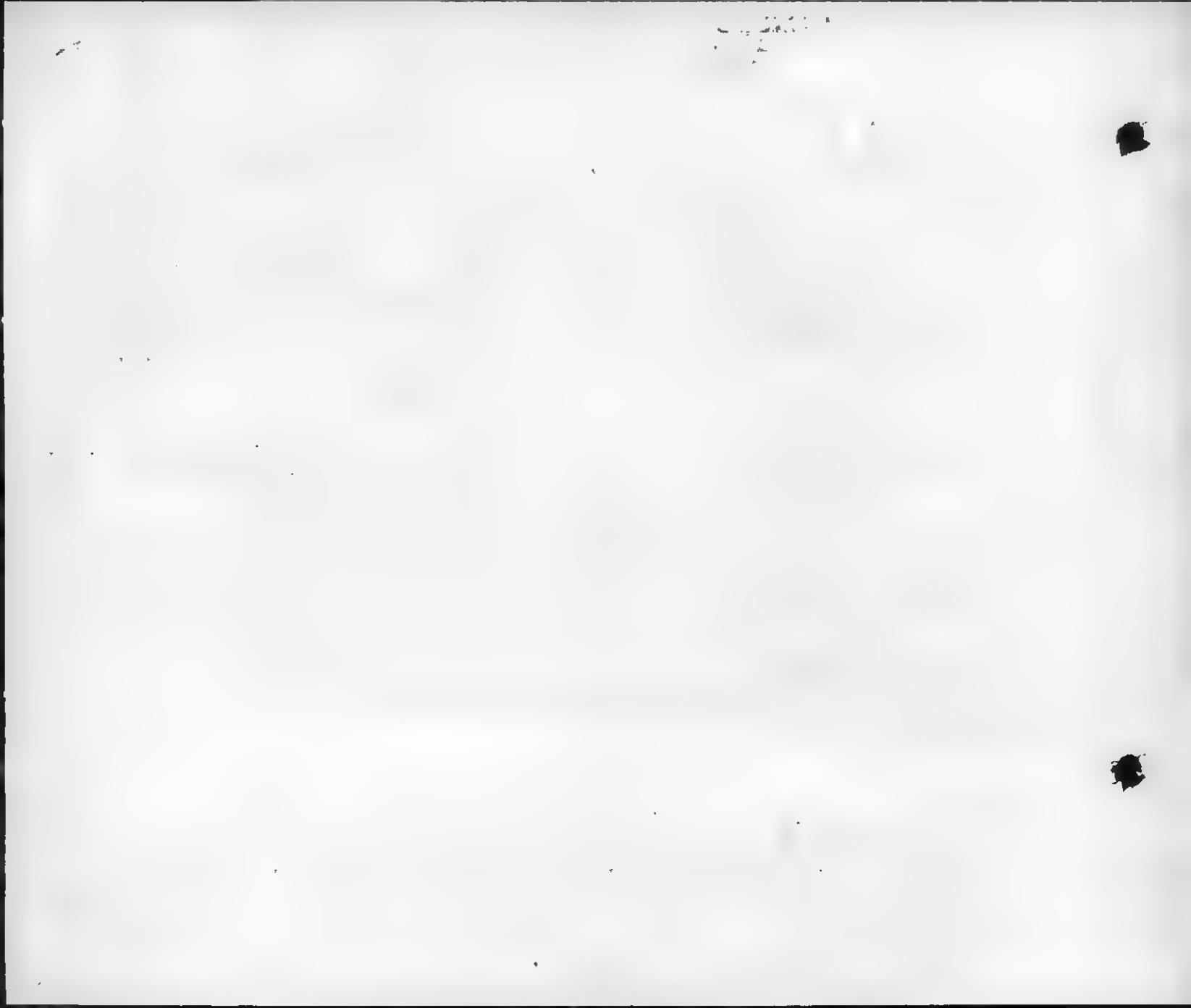
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5126 CERTIFICATE OF DEATH

Reg. Dist. No.

06114

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD 1 Mechanicsville		c. LENGTH OF STAY IN lb 14 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION		e. STREET ADDRESS RFD 1 Mechanicsville	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ophelia	Middle Hailey	4. DATE OF DEATH Month Day Year May 3, 1958
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1907
9. AGE (In years last birthday) 51 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	11. KIND OF BUSINESS OR INDUSTRY Home	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	15. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	17. SOCIAL SECURITY NO. —	18. INFORMANT Edward Hailey RFD 1 Mechanicsville, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH Generalized coartaria anemia, Carcinoma of uterus with frozen pelvis 3 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____, M, from the causes and on the date stated above. ACTUAL SIGNATURE J. Roy Guyther M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/6/58	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hensley Funeral Home Baltimore, Md.		24a. REC'D BY REGISTRAR DATE MAY 6 '58	24b. REGISTRAR'S SIGNATURE W. Leibach



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6127

CERTIFICATE OF DEATH

Reg. Dist. No.

06115

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mechanicsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital			d. STREET ADDRESS		

3. NAME OF DECEASED (Type or print)		First Reginald	Middle Daniel	Last Harper	4. DATE OF DEATH Month May	Month Year 1958
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 27, 1899	9. AGE (In years last birthday) yrs 59	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS Days 22	12. Hours Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
---	---	---	--

13. FATHER'S NAME Daniel Harper	14. MOTHER'S MAIDEN NAME Lula Harris
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Address Lula Harper Mechanicsville, Maryland
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
<i>Arteriosclerotic heart disease</i>			
<i>Diabetes mellitus</i>			

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Mechanicsville	(County) (State)

21. I certify that I attended the deceased from <i>Maryland</i> , 1958, to <i>May 18, 1958</i> , that I last saw the deceased alive on <i>May 10, 1958</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. Clarke Mattingley</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>Mechanicsville, Md.</i> DATE SIGNED
--

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/23/58	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Morganza, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley	ADDRESS Leonardtown, Md.	24a. REC'D BY REGISTRAR DATE MAY 23 '58	24b. REGISTRAR'S SIGNATURE <i>Albert Smith</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

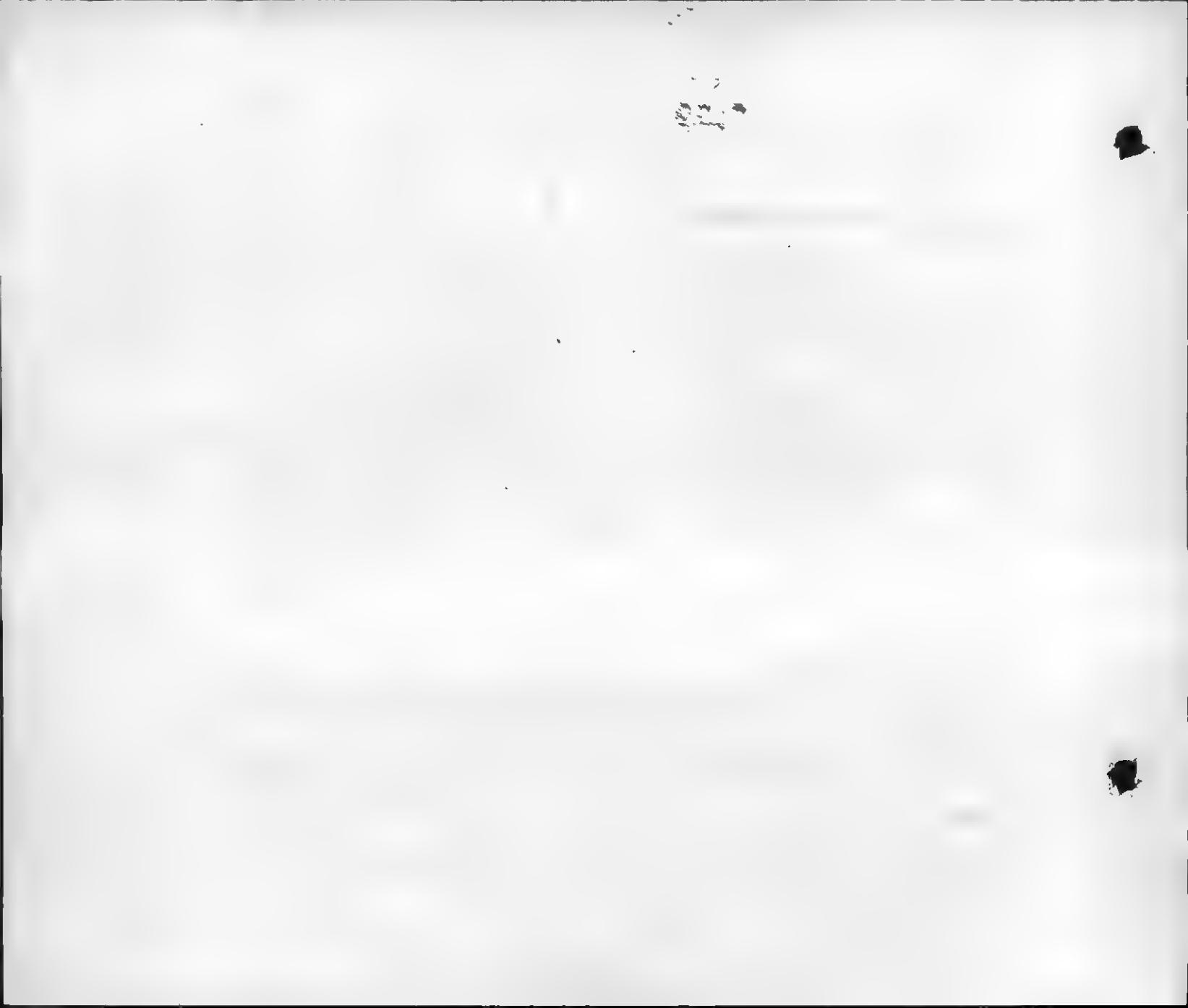
6128 CERTIFICATE OF DEATH

Reg. Dist. No.

06116

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 5 hrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Ellie	Middle Hensley	Last Hensley
4. DATE OF DEATH 5/ 24	Month 5	Day 24	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1887
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Crockett Whiteard		14. MOTHER'S MAIDEN NAME Rendey Hagee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Douglas Hensley		Address Coeburn, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD. DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 10 min			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month May	Day 23	Year 1958
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mechanicsville, Md.		20f. (City or town) Mechanicsville
(County) Md.	(State) Md.		
21. I certify that I attended the deceased from 5/23 , 19 58 , to 5/24 , 19 58 , that I last saw the deceased alive on 5/23 , 19 58 , and that death occurred at 171 M. from the causes and on the date stated above. ACTUAL SIGNATURE J. Roy Guyther PHYSICIAN'S NAME (Type) J. Roy Guyther, MD			
ADDRESS (Street, city or town, state) Mechanicsville, Md.			
DATE SIGNED 5/25/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/27/58	22c. NAME OF CEMETERY OR CREMATORIAL Little Tom Cem.	22d. LOCATION (City, town, or county) Banner
		(State) Va.	
23. FUNERAL DIRECTOR'S SIGNATURE P. B. Robinson		ADDRESS Leonardtown, Md.	24a. REC'D BY REGISTRAR DATE MAY 28 '58
		24b. REGISTRAR'S SIGNATURE Alfred Deenach	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5129 CERTIFICATE OF DEATH

Reg. Dist. No.

06117

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 1 may be retained by the hospital or attending physician and completely filled in by the physician. To HUNTER DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-transit period. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Marys		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. Marys City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		d. STREET ADDRESS Rural	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mary	Middle G	Last Kohut
4. DATE OF DEATH	Month May	Day 2	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1895
9. AGE (In years last birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 18	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY domestic	11. BIRTHPLACE (State or foreign country) Czechoslovakia	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George Chizmar	14. MOTHER'S MAIDEN NAME Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. -----	17. INFORMANT Michael J. Kohut - St. Marys City, Md.	Address -----
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure			
DUE TO 4 1/4			
INTERVAL BETWEEN ONSET AND DEATH 3 days.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Thrombosis			
DUE TO 1 hour.			
C (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Leonardtown, Md.	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from April 30, 1958 , to May 2, 1958 , that I last saw the deceased alive on May 2, 1958 , and that death occurred at 9 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Leonardtown, Md.			
ACTUAL SIGNATURE Robert T. Fuchs	DATE SIGNED 5/3/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/6/58	22c. NAME OF CEMETERY OR CREMATORIUM St. James	22d. LOCATION (City, town, or county) (State) St. Marys City, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE MAY 7 '58	24b. REGISTRAR'S SIGNATURE Rebecca



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6130 CERTIFICATE OF DEATH

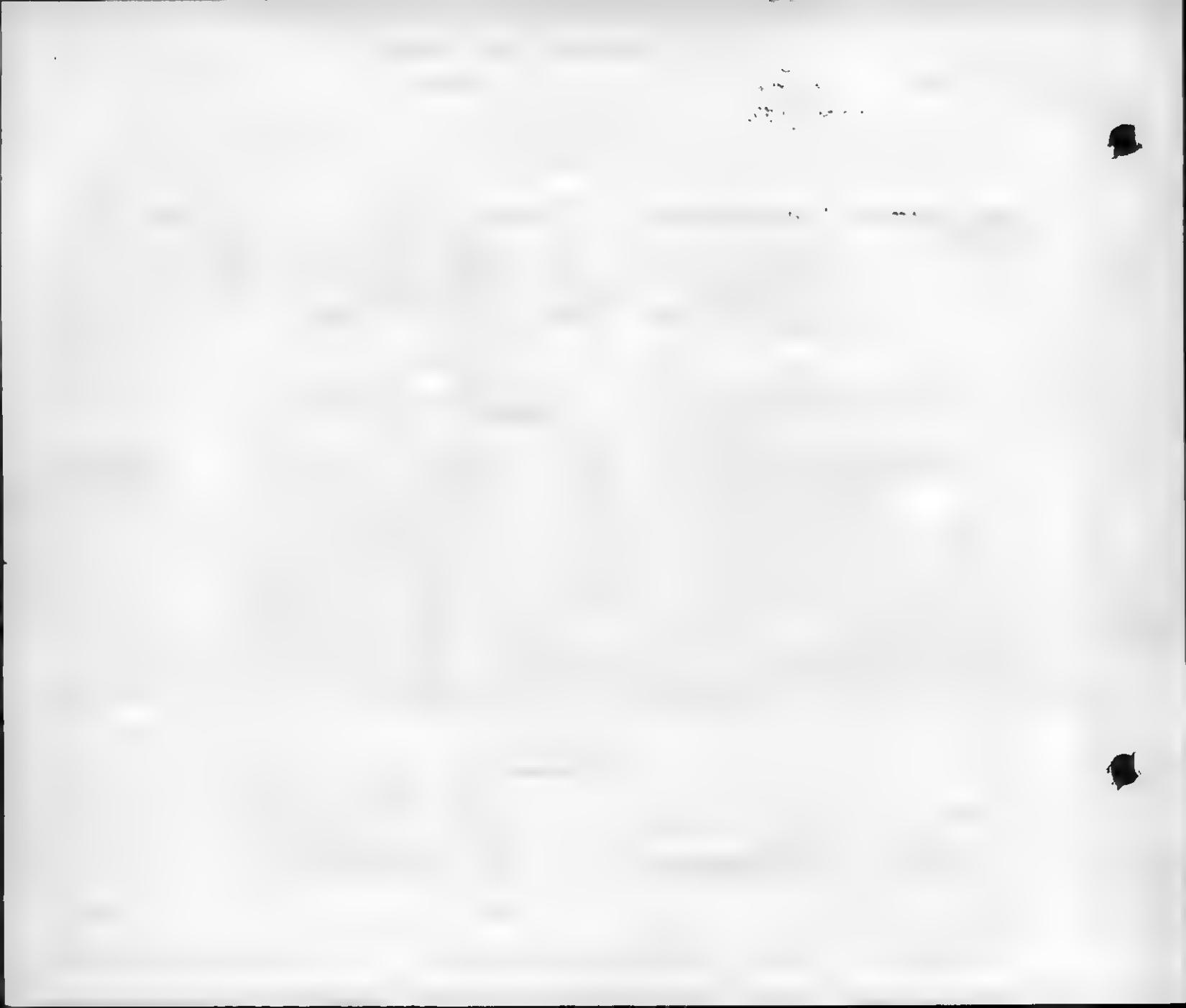
06120

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's		d. STREET ADDRESS (see b.c.)	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Mattingly	Middle Mattingly	Last Mattingly
4. DATE OF DEATH	Month May	Day 19	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1958
9. AGE (In years last birthday) yrs. 4	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Joseph Aloysius Mattingly		14. MOTHER'S MAIDEN NAME Mary Catherine O'Connell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT mother	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ATELECTASIS PREMaturity		INTERVAL BETWEEN ONSET AND DEATH 5 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) MATERNAL VAGINAL BLEEDING 5 wks. p.t. de/1-18	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 5-18 , 19 57 , to 5-19 , 19 57 , that I last saw the deceased alive on 5-19 , 19 57 , and that death occurred at 1414 M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Mechanicsville, Md.	
ACTUAL SIGNATURE Dr. David Mossman		DATE SIGNED 5-19-58	
PHYSICIAN'S NAME (Type) Dr. David Mossman		Mechanicsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/19/58	22c. NAME OF CEMETERY OR CREMATORIAL Our Lady's	22d. LOCATION (City, town, or county) Melville Neck, Md.
23. FUNERAL DIRECTOR'S SIGNATURE McLain Mattingly Leonardtown, Md.		24a. REC'D. BY REGISTRAR MAY 22 58	24b. REGISTRAR'S SIGNATURE Quesenberry
2078350X5T			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6131 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06121

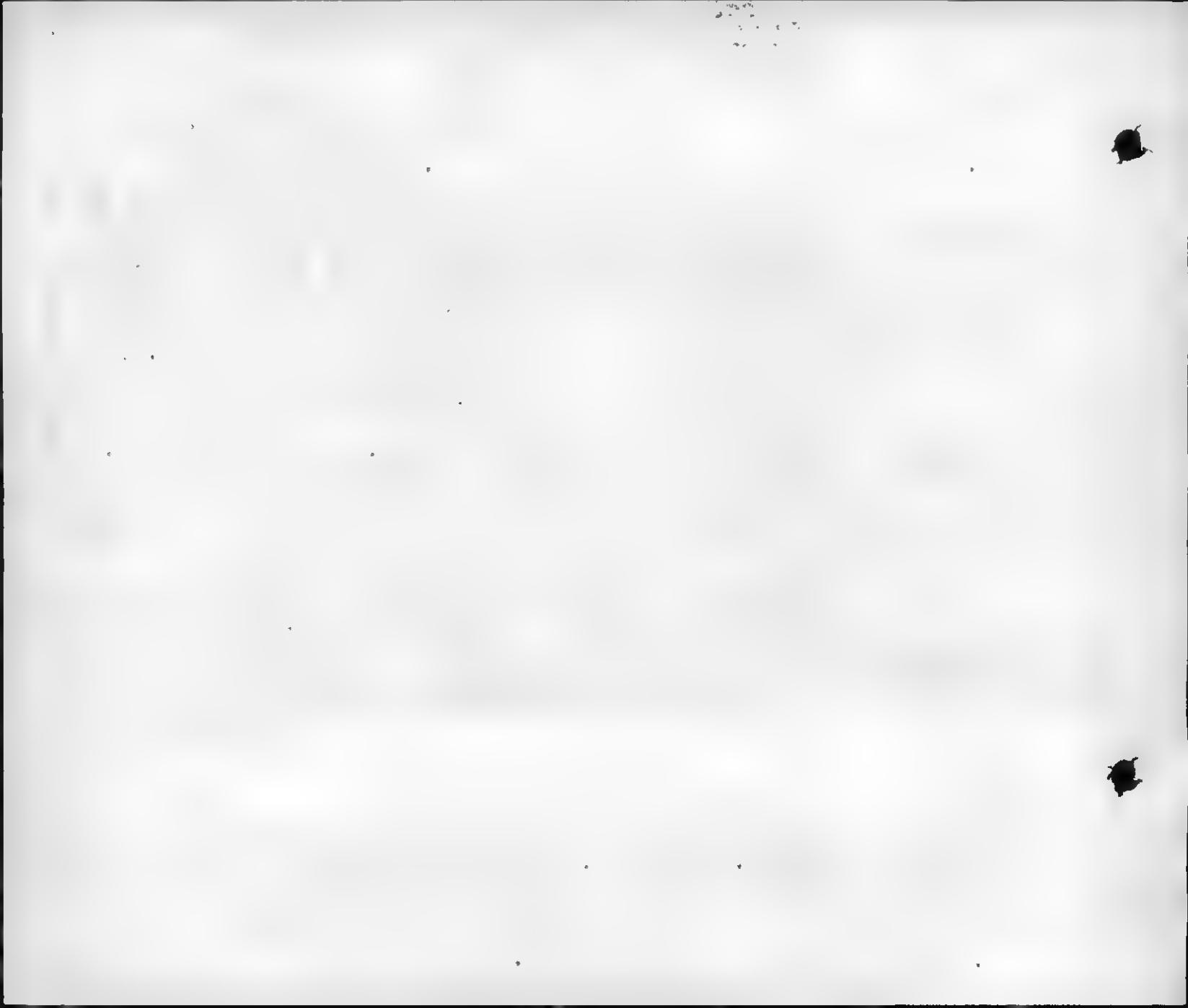
Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

1 If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. George Island		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X St. George Island	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		e. IS RE D.N. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bradley Irving Rice		First	Middle	Last	4. DATE OF DEATH May 17, 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH Oct. 19, 1918	9. AGE (in years last birthday) 39 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Norman Rice		14. MOTHER'S MAIDEN NAME Ruth Baden		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		Address Norman Rice St. George Island, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BURNS DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH immediate	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II at item 18) Burned to death while sleeping in home apparently due to cigarettes			
20c. TIME OF INJURY Hour 4:05 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> Home		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) At George Is. At Mary's	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>W.D. Boyd</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/20/58	
EXAMINER'S NAME (Type) William D. Boyd M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/21/58		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 22 '58	
				24b. REGISTRAR'S SIGNATURE <i>Archaeum</i>	

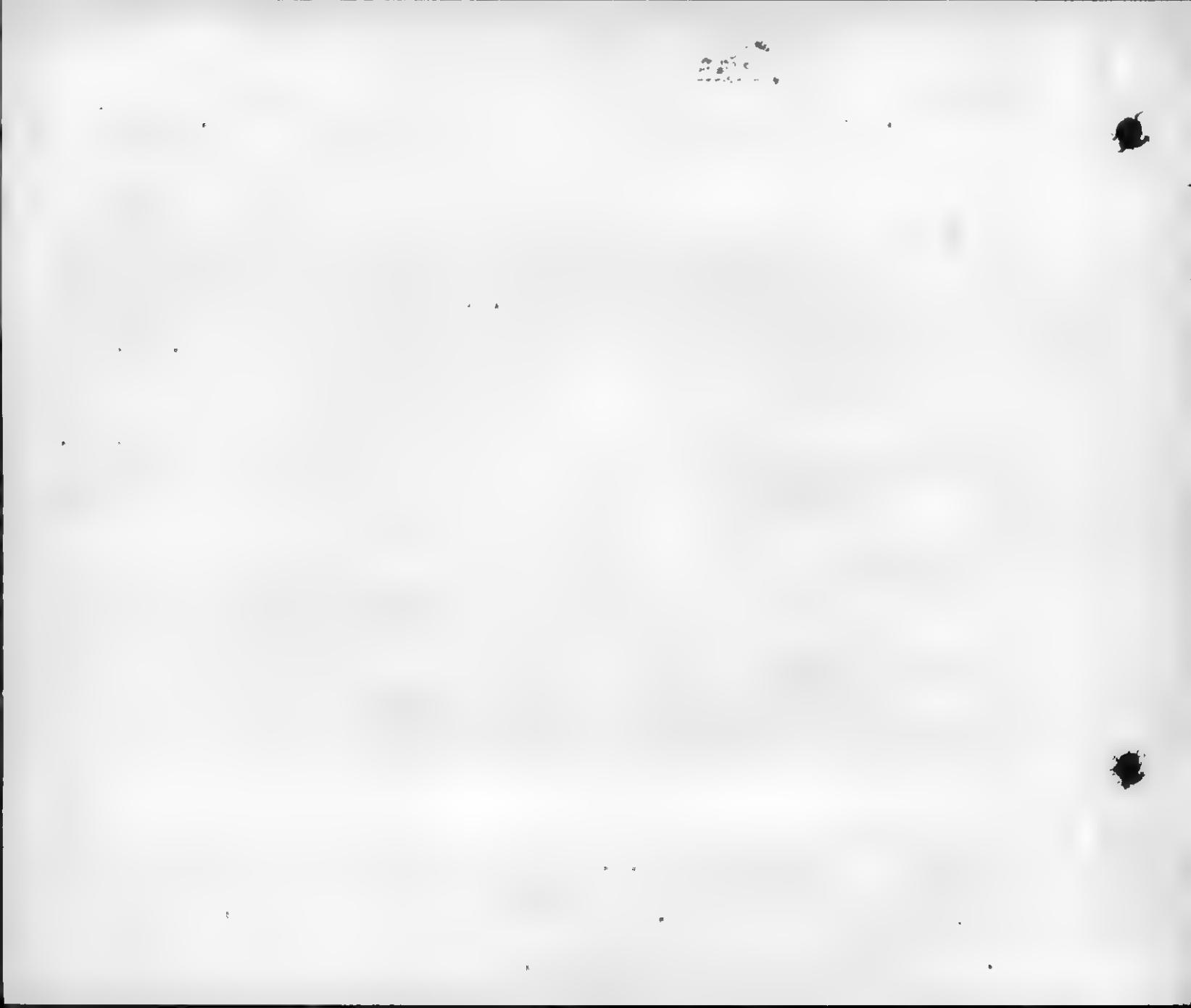


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
6132 CERTIFICATE OF DEATH

06122

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Park Hall Rural		c. LENGTH OF STAY IN 1b 6 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda Park		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Nellie	Middle Smith	Last	4. DATE OF DEATH Month May	Month 11	Day 19	Year 58
S SEX Female	6 COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 25, 1874	9. AGE (In years at birthday) 84 yrs	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Welfare Board Leonardtown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 2215		Cerebral Vascular Accident		DUE TO (b) Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 2-3 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.	(County) ADDRESS (Street, city or town, state) DATE SIGNED 16 May 1958	
21. I certify that I attended the deceased from April , 19 58 , to 11 May , 19 58 , that I last saw the deceased alive on 11 May , 19 58 , and that death occurred at M. from the causes and on the date stated above. ACTUAL SIGNATURE Ernest D. Rehm M.D.								
PHYSICIAN'S NAME (Type) Ernest Rehm M.D.		Great Mills, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/16/58		22c. NAME OF CEMETERY OR CREMATORIUM St. Aloysius		22d. LOCATION (City, town, or county) Leonardtown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 20 '58		24b. REGISTRAR'S SIGNATURE Dee Smith		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6133 CERTIFICATE OF DEATH

06123

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY St Mary's Co MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE Maryland b COUNTY St Mary's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown Rural	c. LENGTH OF STAY IN lb 12 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown, Md.
	d. STREET ADDRESS
	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Charles	Middle Albert	Last Stancliff	4. DATE OF DEATH	Month May	Day 22	Year 1958
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5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 8 th 1881	9. AGE (In years last birthday) 76 yrs	10. UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Government	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME Wm. Winfield Stancliff	14. MOTHER'S MAIDEN NAME Flora A. Grandall		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		New Violet Stancliff, Leonardtown, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	19. INTERVAL BETWEEN ONSET AND DEATH
Pneumonia	
Stroke	

20a. MEDICAL CERTIFICATION	20b. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
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20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I attended the deceased from Feb 27 th 1958 to May 22 nd 1958, that I last saw the deceased alive on May 22 nd 1958, and that death occurred at 9:35 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE Charles Greenwell	M.D.	Leonardtown, Md.
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22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 5/26/58	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county) Washington D.C.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home	ADDRESS Washington, D.C.	24a. REC'D BY REGISTRAR DATE MAY 27 1958	24b. REGISTRAR'S SIGNATURE
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

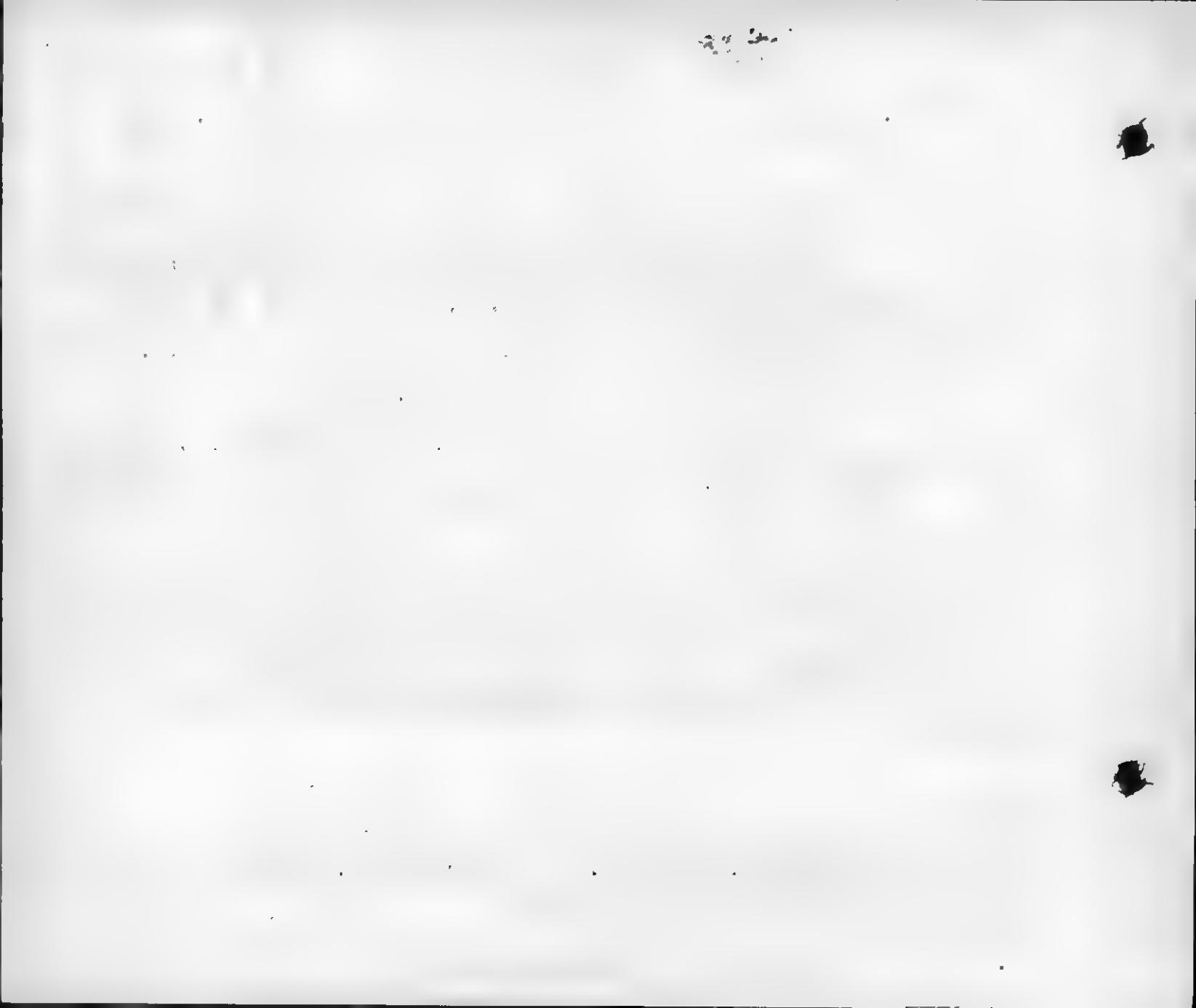
6134

CERTIFICATE OF DEATH

06124

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Maddox	c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Maddox	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Thomas	Middle Marion	Last Turner
4. DATE OF DEATH	Month May	Day 12,	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1873
9. AGE (In years last birthday) yrs 85	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farm	11. BIRTHPLACE (State or Foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Edward Turner		
14. MOTHER'S MAIDEN NAME Martha Lomax			Address
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Margaret V. Turner Maddox, Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 X DUE TO Hypertension cardio. vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Renal Shut down (c)			
INTERVAL BETWEEN ONSET AND DEATH 16 yrs. Same			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Leonardtown, Maryland (County) Charles (State) Maryland
21. I certify that I attended the deceased from May 15, 1957, to May 12, 1958, that I last saw the deceased alive on May 10, 1958, and that death occurred at 5:00 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Joseph E. Gill M.D. ADDRESS (Street, city or town, State) Leonardtown, Maryland DATE SIGNED 5/12/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/14/58	22c. NAME OF CEMETERY OR CREMATORIUM Christ Church
22d. LOCATION (City, town, or county) Chaptico, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR DATE MAY 13 '58	24b. REGISTRAR'S SIGNATURE R. Clarke



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6135

CERTIFICATE OF DEATH

Reg. Dist. No.

06125

1. PLACE OF DEATH a. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN lb 5hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dameron				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First James	Middle Henry	Last Vandervere	4. DATE OF DEATH Month May	Month 22,	Day 19	Year 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 22,	9. AGE (In years last birthday) 51	IF UNDER 1 YEAR Months 51	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? N.J. U.S.A.		
13. FATHER'S NAME Richard Vandervere				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary Vandervere		Address Dameron, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Ganglionic arterio-sclerosis DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 6 hours								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Great Mills, Maryland		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Jan 16, 1958 to May 22, 1958 , that I last saw the deceased alive on May 28, 1958 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Great Mills, Maryland								
ACTUAL SIGNATURE P. J. Bean M.D.								
DATE SIGNED 7/22/58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/26/58		22c. NAME OF CEMETERY OR CREMATORIAL Mt Zion		22d. LOCATION (City, town, or county) St. Mary's		
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		ADDRESS W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE MAY 27 1958		24b. REGISTRAR'S SIGNATURE Alt. Suduch		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be defaced for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6136 CERTIFICATE OF DEATH

Reg. Dist. No.

06126

1. PLACE OF DEATH o. COUNTY St. Mary's		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills		c. LENGTH OF STAY IN 1b 4 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Great Mills			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Kitty	Middle Washington	Last 	4. DATE OF DEATH Month May	Month 2,	Day 1958
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 1, 1883	9. AGE (In years from birthday) 75 yrs.	IF UNDER 1 YEAR Months 	IF UNDER 24 HRS. Days 	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Barns		14. MOTHER'S MAIDEN NAME Lottie Barns					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Agnes Edison		Address Great Mills, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Central hemorhage					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO		Generalized arteriosclerosis				10 years	
(b) Arteriosclerotic heart disease						5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 8, 1958 to May 2, 1958 , that I last saw the deceased alive on March 1, 1958 , and that death occurred at 9 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Great Mills, Maryland	
ACTUAL SIGNATURE P.J. Bean M.D.						DATE SIGNED May 3/58	
22a. BURIAL, CREMATION, BURIAL (Specify) Burial		22b. DATE THEREOF 5/6/58		22c. NAME OF CEMETERY OR CREMATORIAL Holy Face		22d. LOCATION (City, town, or county) (State) Great Mills, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 8 '58		24b. REGISTRAR'S SIGNATURE Albert J. Smith	

